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NATIONAL HOSPITAL PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT

NORTHEASTERN IOWA

November 3-7, 1986

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PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

TABLE OF CONTENTS

		PAGE
1.0	**OVERVIEW OF NORTHEASTERN IOWA**	1
2.0	**SCOPE OF INTERVIEWS**	4
3.0	**HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS**	6
	3.1 Competitive Environment	6
	3.2 Hospital Financial Performance	7
	3.3 Responses to PPS	8
	3.3.1 Cost Reduction	8
	3.3.2 Competitive Actions	9
	3.4 DRG and Cost Monitoring of Physicians	14
	3.5 Criticisms of PPS	15
	3.5.1 The Update Factor	16
	3.5.2 The Urban-Rural Rate	16
	3.5.3 Rural Wage Index and Nonlabor Costs	16
	3.5.4 Outlier Payments	17
	3.5.5 Capital Payment Policy	17
	3.5.6 Physician Incentives	18
	3.5.7 Quality of Care	18
4.0	**PPS AND ALTERNATIVE HEALTH PLANS**	20
	4.1 Structure of the Industry	20
	4.2 Competition	20
	4.3 Contracting with Hospitals	21
	4.4 Contracting with Physicians	21
	4.5 Marketing Strategy and Benefit Availability	22
	4.6 Utilization Review	23
	4.7 Medicare Enrollment	25
5.0	**MEDICAL PRACTICE PATTERNS UNDER PPS**	26
	5.1 Background	26
	5.2 Admission Controls	26
	5.3 LOS/Intensity Controls	27
	5.4 Specialization and Other Responses to PPS	27
	5.5 Quality of Care Impacts	28
6.0	**THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS**	29
	6.1 Discharge Planning	29
	6.2 Home Health Agencies	30
	6.3 Nursing Homes	31

TABLE OF CONTENTS Continued

		PAGE
7.0	**PROGRAM OPERATIONS**	33
7.1	Peer Review Organization	33
7.1.1	Administration	33
7.1.2	Super-PRO Ratings	33
7.1.3	Quality Assurance and Record Review	34
7.1.4	Denials and Sanctions	34
7.2	Fiscal Intermediary	34
7.2.1	Administration	34
7.2.2	Claims Processing	35
7.2.3	Utilization Review	35
7.2.4	Relations with HCFA	37

1.0 OVERVIEW OF NORTHEASTERN IOWA

The Northeastern Iowa site is defined as including the Waterloo/Cedar Falls MSA (Black Hawk and Bremer counties) plus adjacent rural counties. Both Waterloo and Cedar Falls lie in Black Hawk County (population 138,000), while Bremer county has a population of only 25,000. This region is a rich farming area with virtually 100 percent of the land outside the towns under cultivation by family farmers. Waterloo, population 75,000, is a marketing and industrial center for the farm economy of this region. This site was chosen because it affords relatively easy access to a large number of rural hospitals in an area undergoing economic changes.

The largest employer has historically been John Deere and Company, a manufacturer of agricultural machinery such as tractors and combines. In recent years, Iowa's farm economy has been in a serious recession, plagued by low prices for agricultural commodities and foreign competition. The recession has severely affected John Deere, whose Waterloo employment has fallen from roughly 16,000 to 6,000. Another major employer, the Rath Meatpacking Company, has closed altogether. Cedar Falls (population 36,000), adjacent to Waterloo, contains the University of Northern Iowa. The economy of this college town has been less affected by the farm crisis. The declining economy of the region has caused a loss of population, especially of young people. The economic malaise has a number of implications for the region's health care system. Because the timing of these effects coincides with the advent of PPS, the effects are difficult for either participants or observers to distinguish from those of PPS payments.

The Waterloo-Cedar Falls metropolitan area contains three hospitals, one of which resulted from a merger approximately a year ago. One of the three urban hospitals has about 500 acute-care beds (in two units a mile apart), another, about 200 beds; and the third, about 80 beds. All of these hospitals, and the region's rural hospitals, are non-profits. The 500 bed "medical center" is the only area hospital with any teaching activity: it has a family practice residency to train physicians for practice in rural areas. This hospital is Catholic-affiliated. Within a 25-30 mile radius from the urban core lie six smaller hospitals. Two of the six essentially rural hospitals are in Bremer county, part of the Waterloo MSA, and are receiving the PPS urban rate. None of the rural hospitals are sole community hospitals or rural referral centers.

Together with the area's depressed economy, PPS has put severe financial and occupancy pressures on Waterloo area hospitals, especially the rural ones. Nevertheless, as a result of their own responses to the situation, and alternate sources of funds, virtually all area hospitals are remaining open. Moreover, PPS has been the catalyst for salutary changes in practice patterns and improvements in hospital efficiency. Active PRO review has slashed unnecessary admissions. The per case basis of PPS payments has encouraged consolidation and conversion of underutilized hospital facilities.

To this point, PPS has not had a marked adverse effect on beneficiary access to providers or on the quality of care. The financial viability of several rural hospitals in the area is tenuous, however, partly as a result of PPS and it is unclear if they will survive in the long-run. If they do not, a significant travel burden will be imposed on some of the rural elderly. In addition, hospital discharges can be characterized as earlier and sicker. This change is imposing added recuperation costs on the elderly and the aftercare industry. Thus, some of the cost "savings" of PPS are not systemic, but are merely cost shifting.

The most vociferous complaint about PPS, especially from physicians, was the intrusiveness and sometimes seeming arbitrariness of PRO regulation. PRO review, done retrospectively, or based on inherently inadequate records or telephone conversations, is said to lead to perverse results at times. Respondents complain about the denial of admissions they feel are clearly justified. There is less complaint regarding the indirect financial incentives of PPS. Hospital administrators accept being put at financial risk for their practices. However, they dislike what they perceive as the arbitrary manipulation of the PPS update factor and the inequities of the urban-rural rate. Further, they are nervous about the end of the capital pass-through.

This rural northeastern Iowa area has one five-year-old HMO, a subsidiary of the area's major employer. There is also a nascent Blue Cross-sponsored PPO. The solid financial backing and wide consumer choices offered by the existing plan, coupled with the area's declining economy, precludes entry. The HMO contracts with all area hospitals and pays hospital-specific DRG rates for the majority of its hospitalizations, excluding Medicare admissions, which are paid at the PPS rate.

Plan physicians are encouraged to control utilization and costs by bearing the risk for approving inappropriate hospital admissions and by sharing in any deficits or surpluses generated from the use of physicians' services. In addition, utilization review is concurrent and careful, although Medicare admissions are not reviewed until the plan is responsible for the co-insurance costs. In the last five years, utilization has fallen from 800-1100 days annually per 1,000 population to only 450-490 days.

The most acutely felt effects of PPS on area physicians are reportedly the latter's reluctance to admit Medicare patients for fear of PRO sanctions and the widely-observed trend to outpatient surgery which, doctors note, predates PPS. Many of the complaints about the PRO (the Iowa Foundation for Medical Care) appear to reflect basic differences in organizational goals. In part, this antagonism may have been brought on by a lack of communication from the PRO to providers about criteria used to evaluate medical necessity and appropriateness. Without an understanding of the standards used to judge patient care, PRO actions could easily be interpreted as arbitrary, capricious, and overly restrictive.

In contrast, the PRO's range of activities appears highly developed. For example, objectives are tailored to Iowa's patient mix and providers. Once problems are identified, plans of actions are developed to focus provider attention and change their behavior. Moreover, the use of small area analysis allows the PRO to compare regional differences in Iowa's practice patterns and identify areas for focussed review.

Hospitals appear to leave physician monitoring largely to the PRO. In general, institutions' pressures on admitting physicians to discharge earlier are indirect and subtle, not usually a matter of explicit badgering by nurse reviewers. While most doctors bemoan "slower, sicker" admissions and "quicker, sicker" discharges under PPS, none are convinced that quality of care is being compromised. On the positive side, medical care is also acknowledged to be better documented now with improved oversight and review and reportedly more education of patients for self-care.

This latter conclusion of physicians stands in contrast to that of hospital discharge planners who report that patient teaching and training during the current shorter hospital stays have been significantly curtailed. Discharge planning occurs much earlier during the hospital stay than prior to PPS and increasingly involves the nursing staff. It is less common now for discharge planners to await physician orders before beginning their activities.

PPS has encouraged earlier discharging of sicker patients, but providers feel this has rarely resulted in poor quality of care being delivered to Medicare beneficiaries. Occasionally, legitimate admissions are delayed, due to both patients and physicians being overly cautious about admitting restrictions. Given the excess capacity of hospital beds in this area, many hospitals have developed SNF units and swing beds. Swing beds in hospitals with discrete long term care units present an opportunity for misuse--i.e., the swing beds could be used simply to augment revenues.

Home health visits have increased considerably as a result of PPS. In an effort to meet this need, and to generate revenue in an era of declining inpatient volume, hospitals have started their own home health programs. These programs have taken business away from the long-standing VNA and in one case is meeting an unfulfilled need of providing high tech services.

In general, all programs are delivering more skilled care in the home setting, most of which has not been detrimental to patient care. The increase in skills required of home health nurses has increased the in-service training they receive. Other additional costs borne by this sector of the aftercare industry include the training, teaching, and assessing of patients, none of which are covered services by Medicare. There is some evidence that certain home care programs are selectively offering their services to patients with adequate resources or who will clearly qualify for skilled services under the Medicare program. Patients not meeting these requirements are referred (economic transfer) to other home care programs. Because hospitalizations are more closely monitored and Medicare's definitions of covered services for post-hospital care are limited, there is reportedly an increasing number of patients who fall between the cracks in the health care system.

2.0 SCOPE OF INTERVIEWS

The Waterloo area site visit was conducted with a series of interviews both inside and outside hospitals. Participating institutions included two of the three hospitals in the Waterloo-Cedar Falls metropolitan area: one, the 500-bed medical center, the other, a hospital with fewer than 100 beds. In addition, four smaller, outlying hospitals participated in the study. One is a 45 bed hospital about 15 miles from Waterloo that receives the PPS urban rate. The three rural hospitals are all 25-30 miles from Waterloo and all have 30-50 acute-care beds, and 50-60 nursing home beds. Two are county hospitals and one is a municipal hospital.

A total of 51 interviews were completed over a five day period (see Table 1). Six hospital Chief Executive Officers, six Chief Financial Officers, and one HMO Marketing Director were questioned in the areas of hospital and HMO competition. In the inpatient utilization and patient management area, six UR coordinators, six chiefs of staff or medical directors, and two orthopedic surgeons based outside the hospital were interviewed. The aftercare industry was surveyed through six interviews with hospital discharge planners, three with nursing home administrators, two with HHA administrators, and three at the County Health department.

Interviews focusing on program operations were conducted at the Fiscal Intermediary (FI) and the Professional Review Organization (PRO). The FI for the Waterloo site is Blue Cross of Iowa, located in Des Moines. Interviews were conducted with the Vice President of Government Programs, the Manager of Medical Review for Medicare Part A, the Director of Provider Reimbursement, the Manager for Provider Reimbursement, and the Manager of Data Processing for Medicare Part A. Another day was spent at the PRO, the Iowa Foundation for Medical Care. The Executive Director, the Executive Vice President, Contracts Manager, and the Manager of Data Services were interviewed.

TABLE 1

WATERLOO IOWA SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	Utilization and Patient Management	Aftercare Industry	Program Operations	HMOs
CEOs	6				
CFOs	6				
U/R Coordinator		6			
Medical Director/ Chief of Staff		6			
Orthopedic Surgeons		2			
Discharge Planners			6		
Iowa PRO				4	
Fiscal Intermediary				6	
Nursing Home Administrators			3*		
Home Health Agency Administrators			2		
County Health Department			3		
HMO Representative					1
Total Number of Interviews	12	14	14	10	1

*Includes 2 Director of Nursing at hospital based SNFs

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Environment

All hospital administrators participating in the northeastern Iowa case study feel competitive pressures. The widely-spaced rural hospitals have some geographical monopoly power over nearby residents, but definite competition for patients exists at the fringes of each rural hospital's market area. However, the rural hospitals' main competition comes not from each other, but from the larger urban hospitals. Because the Waterloo/Cedar Falls urban area is a 30 minute drive for residents of the rural areas, they can, and often do, exercise the option to visit the urban hospitals. The three hospitals in Waterloo/Cedar Falls compete with each other for urban admissions and also for referrals from the rural hospitals. However, the urban hospital nearest to a given rural hospital has an advantage in attracting those rural referrals.

At the fringes of their market area, the Waterloo/ Cedar Falls hospitals compete for rural referrals with hospitals in other urban areas, especially hospitals in Cedar Rapids, a city of 110,000 people located 65 miles down an Interstate highway to the southwest. Previously, a "gentleman's agreement" had established the boundary between the market areas of the Waterloo and Cedar Rapids hospitals as being a certain east/west highway lying between the two cities. In the last few years, this implicit agreement has reportedly been broken by the Cedar Rapids hospitals: they are said to be encroaching on the traditional Waterloo market area in search of patients. In the tertiary care market, the University of Iowa hospitals in Iowa City (90 miles to the southeast), the Mayo Clinic in Rochester, Minnesota (120 miles to the north), and the Gundersson Clinic in LaCrosse, Wisconsin (150 miles to the northeast) compete for referrals from the Waterloo/Cedar Falls hospitals.

Thus, competition in the Waterloo area is conditioned by geography and level of care. Rural hospitals compete with each other for primary care patients, especially at the edges of their market areas. In addition, the rural hospitals compete with the urban hospitals, to some extent for primary-care patients, but also for secondary-care patients who could be referred to an urban hospital. Similarly, the urban hospitals compete with each other for primary- and secondary-care patients and rural referrals, and with tertiary-care hospitals out of the area for patients who might be referred there.

In the last few years, competitive and financial pressures on all hospitals to attract patients have increased. This is partly a result of PPS, which pays only on a per-discharge basis. For area hospitals, especially rural ones, Medicare admissions are very important, comprising 35-65 percent of their total admissions. A second pressure comes from the area's economic and population decline, which has significantly reduced the number of non-Medicare admissions and increased the Medicare share of business. The area's economic problems have also raised hospitals' bad debt, increasing the financial pressure on them. A third factor is the area's major HMO, which, about 18 months before the

inception of PPS, began a strict utilization review program that significantly reduced admissions for its enrollees. A final factor is the very aggressive Iowa PRO which has also had a substantial impact in reducing admissions, especially "social" admissions to rural hospitals. In fact, many hospital respondents feel that the PRO has had more impact on hospitals and medical practice than the financial incentives of PPS.

For these reasons, in addition to declining lengths of stay, inpatient occupancy rates are lower in area hospitals than three to six years before. The occupancy drop is most dramatic for rural hospitals. Several rural hospitals have experienced declines from 60-70 percent occupancy to 20-30 percent in the past six years. One rural hospital has averaged less than 1 patient in its inpatient unit at any one time for the previous year and a half, although its occupancy has picked up in the last few months. The occupancy rates of urban hospitals have also fallen, although not as dramatically.

3.2 Hospital Financial Performance

The occupancy declines have put severe financial pressures on virtually all area hospitals since the inception of PPS. Most have lost money for at least one year since PPS was introduced. However, a number of countervailing factors have reduced the financial pressures. One is that inpatient admissions have not simply evaporated, but rather have been shifted to the outpatient setting. Hospitals consistently report that the proportion of same-day or ambulatory surgery has increased from 0-10 percent pre-PPS to 40-50 percent today. Thus, while inpatient units are contracting, outpatient visits and revenues are booming. Second, in case study hospitals, the hospital's Federal amount substantially exceeds its hospital-specific portion. Since their historical costs are below the national urban-rural averages, Waterloo-area hospitals tend to gain from the PPS rates, which are based on averaging of historical costs.

In addition, several idiosyncratic factors have helped certain rural hospitals which at first glance would seem to be in serious trouble because of low occupancy. For example, one rural hospital has subsidized substantial operating losses with investment income from a large endowment. The PPS urban rate is a financial boon to at least one hospital that could be considered to be essentially rural. Several rural hospitals are financially consolidated with nursing homes which are full to capacity and offsetting acute-care losses. One rural hospital has zero debt, and has previously-funded depreciation funds available for capital expenditures. Finally, two of the rural hospitals are county hospitals and one is a municipal hospital; all receive some tax subsidies.

For these reasons, and because of the responses to PPS detailed in the next section, all the hospitals participating in the case study reportedly will survive in spite of sharply reduced inpatient admissions. In just the last few months before the interviews, admissions and occupancy were up in several hospitals. Lengths of stay, which fell when PPS was introduced, seem to be creeping back up because of the greater severity of illness of patients admitted to inpatient beds. Several hospitals which had lost money in the last few years have

reversed their position and had positive margins in the last fiscal year or the first few months of their current fiscal year.

Major use of the retained earnings has been funding depreciation and acquiring or upgrading equipment, or floor space. The excess of revenues over costs has not been used to raise employee wages. Hospitals are wary of increasing their base costs because they feel they can not be sure of their future financial situation. However, a direct correlation does seem to exist between the funds available to these nonprofit hospitals and their rate of technology adoption and capital upgrading.

3.3 Responses to PPS

3.3.1 Cost Reduction

With a fixed, per-case payment, PPS gives hospitals strong financial incentives to reduce costs. Personnel in all the participating hospitals recognize these incentives and are taking steps to at least restrain cost increases. Hospitals in poor financial condition because of low occupancy are especially vigorous in reducing costs, which is necessary to ensure their survival.

Labor expenses comprise the largest portion of hospital costs and are more discretionary than capital expenses. In the Waterloo area, PPS and declining demand have curtailed employment and wage growth for hospital workers. This is where hospitals have achieved their greatest cost savings. In several hospitals, both urban and rural, FTEs were substantially lowered in the past few years, from 10 to 30 percent. Most often, FTEs were reduced through fewer hours per employee rather than layoffs. One hospital had limited its full-time employees to 36 hours per week from 40, another had moved most of its employees from full- to part-time. Variable staffing is also used. One hospital controls the number of hours worked through "trim points," depending on its census. Less frequently, layoffs reduced FTEs. In area hospitals, these have affected both lower- and higher-salaried workers. While inpatient staffing has been reduced, outpatient staffing has often increased, however.

The other component of labor expense is wages. Northeastern Iowa hospitals have tightly restrained wage settlements in the past several years. Most rural hospitals imposed wage freezes for 2-3 years, only recently granting cost-of-living raises. Even physicians have been affected. One rural hospital has saved money by not guaranteeing physicians' incomes anymore. Urban hospitals, with a less precarious financial situation, have been more generous to employees. They have generally given cost-of-living increases to employees for the past several years, although one urban hospital had a four-year wage freeze, recently lifted.

Hospital personnel, especially at the rural hospitals, emphasized the direct connection between their PPS reimbursement and employee compensation. If PPS reimbursement is stringent, hospital employment and wage levels are directly affected because labor costs are the only major potential source of savings. In addition, several rural CEOs noted that

their hospitals are the largest, or one of the largest, employers in town and that the entire economy of the rural area would be jeopardized by the hospital's closing.

Rural hospital managers also believe that they have reduced labor costs as far as practicable at this time and should not be squeezed any further. Several mention the need to maintain standby capacity because theirs is the only hospital in the area. This necessity limits the degree to which staffing can be cut. A minimal level must be maintained to cope with multiple-injury emergencies (e.g., bad car accidents). Moreover, rural managers feel limited in staff reductions by indivisibilities. When two technicians are employed, one can be layed off, this argument goes, but when only one is left s/he cannot be let go. A final factor constraining labor reductions in rural hospitals is state regulations requiring a certain minimal level of nursing staff to be present at all times.

Nonlabor costs have also been reduced. Inventories, especially of drugs, have been pared, group purchasing arrangements have been entered into, generic drugs have been introduced, and records have been computerized. Ten hospitals in Northeast Iowa have combatted their small scale by forming a cooperative to reduce expenses through sharing personnel, technology, and services, and by purchasing as a group. A general "cost-consciousness" among buyers and department heads has been inculcated, more so than pre-PPS. One rural hospital closed an outlying clinic on which it was suffering substantial losses.

The major long-run source of cost-reduction, however, is bed conversion and reduction. With its declining population, this area has been overbedded for a number of years, preceding PPS. Recent admission and length-of-stay reductions attendant on PPS and PRO review have exacerbated this problem. One urban hospital has just completed a major renovation, planned pre-PPS, which reduced its inpatient beds and increased outpatient facilities. Two other large urban hospitals have merged within the past year. Management claims that efficiencies have resulted from consolidating the data processing, laundry, accounting, nursery, and obstetrics/ gynecology facilities of the two previously-underutilized acute-care units. Another large facility plans eventually to turn one of its buildings into a sub-acute care unit, thereby eliminating 250 acute-care beds, about 30 percent of the total market capacity. Rural hospitals are also converting and decertifying acute-care beds. The space opened up is now used for swing beds, rehab beds, intermediate and skilled nursing beds, hospice beds, outpatient surgery, ambulatory testing, and waiting rooms.

3.3.2 Competitive Actions

3.3.2.1 Price Competition

PPS does not allow price competition because prices paid to hospitals for each Medicare discharge are fixed. However, price competition occurs when hospitals set charges, which are paid by some payors, or negotiate discounts for HMO, IPA, or PPO business.

In this area of Iowa, both forms of price competition are evident, although not intense. Most hospitals set charges to cover costs. Volumes and associated costs are projected for the next year, then charges are set at a level to cover expected expenses plus a margin for capital acquisition, renovation, etc. However, competitive conditions are a consideration in setting charges. Most hospitals survey comparable hospitals when setting charges and keep their rates similar (i.e., competitive). In the Waterloo/Cedar Falls market, two hospitals recently lowered their daily room rate to equal that of a lower-cost third hospital. Rural hospitals keep their room rates below those of the urban hospitals.

Moreover, the margin on ancillary and outpatient testing varies according to perceived elasticities of demand which reflect the degree of competition. One rural hospital administrator feels that mammography charges are constrained by competition from Waterloo hospitals. An urban hospital uses PAP smears as a "loss leader," setting charges below costs to attract women who may then use the hospital for other needs. At this hospital, laboratory and X-ray charges are influenced by those of the competition. In general, emergency room and outpatient charges are determined more by competitive circumstances than inpatient charges because patients pay more out of pocket in these areas, leading to greater price sensitivity. One urban hospital, with the busiest emergency room in the area, keeps its ER charges low to stimulate business, and advertises its emergency room as "lower cost." Some cost-shifting is evident. Certain hospitals have raised charges for services used heavily by charge-paying patients (i.e., non- Medicare or Medicaid patients) because they feel that this is the only way they can increase their revenues.

HMOs, IPAs, and PPOs can create price competition by requiring competitive bidding for the business of their enrollees. In the Waterloo area, the existing HMO could exercise considerable monopsony power because of its large enrollment. However, due to union pressure, this HMO has decided not to engage in competitive bidding, which would result in restricted choice for its enrollees. Instead, it instituted a tough utilization review program about 18 months before the inception of PPS to control costs. This utilization review program has been a major factor in reducing utilization and beds in the area (especially psychiatric beds at one urban hospital), and has acted as an important pre-PPS disciplinary device for area hospitals. In addition, the HMO is reportedly moving toward a single, community-wide rate by DRG, away from paying less to low-cost hospitals than high-cost hospitals.

The nascent Blue Cross PPO has been much more aggressive in promoting price competition. Its recent RFP to Waterloo/Cedar Falls hospitals asked for inpatient/outpatient rates and the discounts each hospital would give to the Blue Cross PPO. Also, Blue Cross has made it clear that price will be a major consideration in awarding PPO contracts, and that not all hospitals will win PPO business. Blue Cross volume is significant (roughly 20 percent for the urban hospitals), and 60 percent of Blue Cross business will be moved to the PPO in the next four years. Thus, the advent of the Blue Cross PPO is an important factor promoting price competition in the Waterloo/Cedar Falls urban market.*

Conversely, the recent merger between two large Waterloo hospitals, though perhaps inevitable because of the area's overbedding, has eliminated a major source of price competition. The merger reduced the number of competing hospitals in the urban area from four to three. Further, one of the merged hospitals traditionally had the lowest costs and charges of the three Waterloo hospitals. It provided significant price competition for the other hospitals, especially the hospital with which it merged. The two merged facilities are separated by only one mile.

In sum, price competition is not currently a major factor in this site. It does exist, however. It is more important for urban than rural hospitals, and for outpatient, diagnostic, and emergency room services than for heavily-insured inpatient services. The Blue Cross PPO, and potentially the Deere HMO, are increasing the intensity of price competition.

3.3.2.2 Nonprice Competition

Nonprice competition among hospitals is often more virulent than price competition. It is the only means of attracting patients under PPS's fixed- price system.

Physicians

Recruiting physicians is crucial to rural hospitals. Small rural hospitals depend on a few doctors to generate business. In some rural areas, getting any physicians at all is the issue. Some rural hospitals have been successful lately in recruiting full-time family practitioners, while other areas have been waiting as long as seven years for a doctor. Visits from urban specialists have recently begun to fill some of these physician gaps. In the past few years, rural hospitals have established specialty clinics staffed part-time by Waterloo specialists. This arrangement is mutually advantageous for the hospitals and doctors. The rural hospitals gain business that would otherwise be lost to the urban hospitals, including follow-up and unrelated visits as patients are familiarized with their hospital. The urban specialists expand their patient base through rural forays; in the Waterloo area, specialists have been forced into the countryside by a saturation of physicians in the cities and declining demand there due to population flight.

In the urban market, competition for physicians varies by specialty. Obtaining certain key specialists is an important goal of urban hospitals. The medical center wants to recruit a neurosurgeon to keep patients currently referred to tertiary-care centers outside Waterloo. It is also trying to recruit gerontologists and other

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*On the other hand, competitive bidding among the widely-scattered rural hospitals is infeasible. In addition, their costs are low. They are paid charges by both the Deere HMO and Blue Cross PPO.

specialists on aging, but is finding that the competition for these physicians is keen. Two other urban hospitals are trying to recruit full-time obstetricians/gynecologists to wrest away some of that market, but are having difficulty doing so. On the other hand, the hospitals hold the upper hand in bargaining with physicians in other specialties because of doctor oversupply and reduced demand. These specialists contact the hospitals, requesting affiliation.

Patient Amenities

Management at several hospitals think patients have been taking a more active role in choosing hospitals lately. Patients are not passive actors who simply go wherever their doctors refer them. In one rural area, a doctor/patient split has arisen. The physician's loyalties are to a hospital which had recently recruited him to the area, while his patients prefer another hospital they have traditionally patronized. Waterloo-area hospitals have recently upgraded patient amenities in an attempt to win business. Special dinners for husbands and their wives who are giving birth, birthing rooms, accommodations for families of the patient, and renovated rooms are some of the ways patient comforts have been augmented.

Promotion

Hospital promotional activity has dramatically increased in the last few years. The promotional budget at one of the urban hospitals runs up to half a million dollars or more. Newspaper and radio advertising is widespread, with television used by several urban hospitals. Outpatient, diagnostic, special equipment and clinics, and obstetrics are among the services most heavily advertised. Informal promotional activities are also common. These include booths at the county fair, T-shirts, public-speaking, audio-visual presentations, and stop-smoking promotions.

Services and Technology

Special services and technologies are an important focus of competition in the Waterloo area. Almost all hospitals are establishing new outpatient and diagnostic services, such as sports medicine and stress tests, to attract patients. Many are built around specific technologies. Rather than each acquiring a piece of equipment, which would be underutilized, rural Iowa hospitals are engaging in extensive sharing of services through mobile units. Mammography, ultrasound, CAT-scan, and echocardiogram are all on wheels in this area. The equipment typically visits each rural hospital for a few days every week or two. Urban hospitals also use mobile technologies -- MRI, which is based in Cedar Rapids, and CAT-scan, which is based at one of the Waterloo/Cedar Falls hospitals. These mobile technologies are quite important in generating volume which formerly was referred elsewhere, and in familiarizing patients with the local hospital.

At a somewhat different level of competition, the medical center in Waterloo is attempting to attract more tertiary cancer work. This effort is built around a new linear accelerator. Currently, the center has 40 percent of Northeast Iowa cancer referrals, but would like to expand its market share to two-thirds. In this endeavor, it competes with the University hospitals in Iowa City and the Mayo Clinic in Rochester, Minnesota.

Hospitals in the Waterloo area attempt to find niches in the medical care market they can fill. Rural hospitals concentrate on primary care. One of the urban hospitals also concentrates on primary care, together with its ER and outpatient business. Obstetrics, a neonatal intensive care unit, and cancer treatment are important to a second urban hospital. Cardiac care is crucial to the third urban hospital.

Vertical integration, diversification, and networking

Hospitals are attempting to solidify their competitive positions by vertically integrating or diversifying into other elements of health care, and by networking with other providers to provide a flow of patients or expertise. For example, several hospitals have integrated into post-hospital care by establishing home health care services or by starting, expanding, or contracting with skilled and intermediate nursing facilities. Hospitals in the area are also vertically integrating into physicians' practices to ensure referrals. This is precipitated by hospitals from other cities buying outlying physician practices in the area. Exclusive contracts to ensure market share are an important focus of competition. At least one Waterloo hospital has tried to establish an exclusive contract with the HMO, but was rebuffed. This hospital does have an exclusive medical services contract with a nearby retirement village, however.

Rural hospitals are diversifying into the whole range of community health needs: education, prevention, diagnosis, and inpatient/outpatient treatment. In some rural areas, even non-medical services such as catering and housekeeping are run out of the hospital. Many rural hospitals have established satellite clinics in outlying communities to expand their market areas. The urban hospitals have attempted to expand their shares of local laboratory work, keeping at home lab work which had previously been sent out of state. One hospital is even doing veterinary lab work, including dog drug tests for the local greyhound track. An urban hospital is now organized as a holding company with profit and nonprofit divisions. The for-profit division has bought a pathology lab and started an SNF unit.

Primary-care networking based on the urban hospitals is a significant development in the area. One Waterloo hospital, beginning over the period 1981-1983, bought one rural hospital, established management contracts with 4 rural hospitals, and clinical contracts with 7 others. The rural hospitals gain expertise, technology, and services from their contracts with urban hospitals. In addition, competition among the urban hospitals has been so fierce that rural hospitals are

able to achieve implicit subsidies through the management contracts: payment to the urban hospital falls short of the value of services received. Other implicit subsidies from urban hospitals are sale of used equipment at below-market prices, help in physician recruitment, and guaranteeing physician income. In effect, through these subsidies the urban hospital is paying the rural hospital for its referrals, although the referral agreement is usually informal rather than formal. The urban hospitals see close contacts with rural hospitals as protecting their turf against encroachment by other large hospitals. Often, they feel they must preempt the competition by aggressively establishing connections with rural hospitals.

3.4 DRG and Cost Monitoring of Physicians

CEOs and CFOs at most Waterloo-area hospitals see reports on their hospital's admissions by DRG. Typically, these compare the charges accrued by a patient to the DRG rate, the actual length of stay to the national average length-of-stay, and list the name of the attending physician. The DRG system thus provides a standard of comparison for the doctor's or hospital's performance. The DRG payment and the national average length of stay are used as benchmarks for reasonable and efficient medical practice.

Hospital administrators focus on DRGs that produce consistent large losses. The administration first studies the reasons for the large losses, then initiates action to reduce them. Usually, administrators do not deal directly with individual doctors. Rather, they work through the medical staff or a utilization review or quality assurance committee. The administrators do not demand or even recommend that physicians cut costs. Instead, they merely make the medical staff aware of DRGs on which large losses have been incurred. Physicians have been educated by the hospital on the general incentives of PPS and the hospital's financial condition, and the medical staff is left to draw its own conclusions.

As an example, one hospital found that it was consistently losing large amounts on pacemaker implants. A study revealed that this was almost entirely due to the high cost pacemaker device ordered by one of its physicians. The administration brought this situation to the attention of the quality assurance committee on which physicians sit, without making a specific recommendation. This administration also found that the hospital was losing significantly on total knee replacements due to above average lengths of stay. The administration tried to persuade the doctor in question to discharge patients to a SNF earlier.

While hospitals take action to lower costs in "losing" DRGs, in no case is there reported evidence that hospitals discourage admissions of certain types of patients on which they expect to lose money. The Waterloo-area hospitals, especially the rural ones, see themselves as community hospitals obligated to treat all patients. They do, however, explicitly try to attract certain kinds of patients (e.g., charge-paying or young patients) on which they make money.

CEOs and CFOs at most hospitals think that administration relations with physicians are good. At all hospitals, the incentives of PPS have been discussed with doctors and they are generally cooperative and prudent in their medical practice. Younger doctors are more aware of and interested in their financial performance than older doctors, who predominate in rural areas.

Rural hospitals have less bargaining power in dealing with physicians than urban hospitals because rural hospitals depend on a small number of doctors for most of their business and it is harder to attract physicians to rural areas. In one rural hospital, the three staff physicians (two of them older) had reportedly refused to economize in their practice styles in spite of the considerable losses suffered by the hospital's inpatient unit. The hospital's administration is unable to discipline these physicians, however, because two of them sit on the hospital's board of directors and all three, on the utilization review committee. Moreover, revoking admitting privileges of the two older physicians would result in the loss of two-thirds of the hospital's volume. A second rural hospital was forced to remove the most active physician from its medical staff for reasons of malpractice. The loss of this doctor's volume placed the hospital in dire financial straits from which it is only recently recovering through the recruitment of replacement physicians.

The sophistication of the analysis of hospital costs varies from hospital to hospital. Charges are often used as an indicator of costs, but many CFOs are aware that charges do not necessarily measure true costs. Most CFOs separate direct, or variable, costs from overhead, or fixed costs. Procedures for allocating fixed costs to cost centers differ in sophistication. One CFO simply doubles direct costs in deriving charges to cover total costs. Another CFO undertakes a complex analysis to determine the contribution of each cost center to total fixed costs. This analysis includes asking hospital personnel the expense of their cost center if built anew, to determine the addition to fixed costs due to each center. Some CFOs also use the difference between the hospital's average costs and marginal, or incremental, costs in their budgeting and charge-setting.

3.5 Criticisms of PPS

Area CEOs and CFOs voiced a number of criticisms of PPS, but virtually unanimously conceded that something had to be done about medical care costs. "There's no question that the PRO has reduced unnecessary admissions. Hell, we used to pull teeth in the hospital." They have no complaints about being put at risk for inefficient practices and evince little nostalgia for cost-based reimbursement. "PPS has forced hospitals to manage, put them at risk for their costs. That's O.K." "PPS has given hospitals more incentives to be efficient. Before, you had to spend a buck to get a buck." But they do have problems with particulars of the current system.

3.5.1 The Update Factor

The update factor is the number one source of complaints and perceived unfairness. Hospital managements see PPS payments rising at a much lower rate than the inflation in their input costs and do not understand why. Several CFOs say that inflation in nonlabor costs (i.e., supplies) is running 7-10 percent and in labor costs 3-5 percent, yet the PPS update factor has been nearly zero. Moreover, the decline in admissions due to the PRO and the concomitant inpatient/outpatient substitution is said to lead to more severely-ill, and hence costlier, patients within DRG. Hospital personnel wonder whether this circumstance is accounted for in the update factor.

Rural hospitals, especially, have reportedly slashed costs as far as possible and can not survive any more years of zero updates. "I've reduced my costs all I can -- all that's left is fixed costs. I have to be given the inflation in my costs as an update factor from now on." "It's unfair to take away hospital gains through the update factor. If the gains are due to greater hospital efficiency, we should be allowed to keep them." "It's unfair to rachet down payments through the update factor. Use the market basket and technology add-on."

3.5.2 The Urban-Rural Rate

Many hospital personnel (especially those in hospitals receiving the rural rate) feel that the urban-rural differentiation of PPS payments is inequitable. They noted similar, essentially rural hospitals being paid differently because one happened to be in an MSA, while the other one was not. They also pointed out hospitals in fairly large cities in other parts of Iowa (e.g., Marshalltown) which do not qualify for the urban rate. Pre-PPS, these hospitals were more complex and costly than the typical rural hospital. Post-PPS, these hospitals are experiencing financial problems and difficulty in competing with hospitals in other urban areas. "The rural rate is killing hospitals in Iowa. Medicare is breaking its promise to the rural elderly in this country."

Historically, according to one interviewee, the cost gap between urban and rural Iowa hospitals was not large. PPS payment policy has introduced more of a differentiation than previously existed, benefitting urban hospitals and penalizing rural ones. "Rural hospitals should be paid the same as urban hospitals for the [primary care] DRGs they do well." Urban hospitals could be paid more for more complex DRGs. One respondent suggested that the DRGs for which rural hospitals should be equally paid could be identified by their frequency of performance in rural hospitals.

3.5.3 Rural Wage Index and Nonlabor Costs

All rural hospital managements complain about their lower wage index. "Frankly, the rural wage index is [expletive deleted]." Without exception, they feel they are in the same labor market as the urban hospitals, i.e., are in direct competition with them for many types of

hospital workers, especially nurses. "I can't pay nurses less than in Waterloo or Cedar Rapids because they are a 30-minute drive down the road." All rural hospitals claim to have lost nurses to the urban areas because of wages. Yet, several rural hospitals admitted that they do pay lower wages for nurses than urban hospitals. What apparently happens is the rural hospitals, with their lower pay, attract only young, inexperienced nurses or ones who have a particular reason for wanting to work in the rural community. "We get either inexperienced nurses which leave once we train them or people who want to stay [in this town] for some special reason."

Rural hospitals claim that, if anything, their nonlabor costs are higher than those of urban hospitals. Rural hospitals often buy their supplies and services (e.g., construction, accounting) from the same urban distributors or firms as the urban hospitals. They may pay higher prices, however, because the suppliers add a transportation charge to service the out-of-the-way rural hospitals. In addition, buying alone, rural hospitals are not able to obtain volume discounts, although most have joined purchasing cooperatives to eliminate this disadvantage.

3.5.4 Outlier Payments

All hospitals complain about PPS outlier payment policy. "We get killed on outliers. Payments don't cover costs." The urban hospitals feel that HCFA's marginal cost, per diem approach to length of stay outlier payments is inadequate. Outliers are usually very sick, complex cases which spend considerable time in intensive care and incur charges (costs?) far in excess of a marginal cost per diem.

The rural hospitals file very few, if any, outlier cases. "[Outlier payments] get taken out of payments to rural hospitals, but we never get that money back -- patients are transferred out of the hospital or into swing beds before they reach outlier status." Expensive cases which do not exceed the outlier threshholds are a problem for rural hospitals. For example, a patient may run up $8,000-10,000 in charges, but the hospital receives the flat DRG rate of $2,000-3,000. The hospital receives no additional payment for these cases, yet a moderate number of them can quickly strain a small hospital's financial resources. This situation would be remedied, as has been suggested, by a hospital-based, rather than a case-based, outlier payment system.

3.5.5 Capital Payment Policy

Several distortions in capital expenditures caused by the current pass- through of depreciation and interest expenses are evident. Maintenance of old capital as opposed to purchase of new capital appears too low. Personnel at one hospital said that because Medicare does not reimburse maintenance expenditures, but does fully reimburse depreciation and interest, they simply buy a new machine (e.g., typewriter) when an old one breaks down rather than repair the old machine. Moreover, the capital pass-through causes a bias in favor of labor-saving technology. That is, with operating expenses (primary labor) capped by the DRG rate,

but capital a pass-through, hospitals have an incentive to substitute capital for labor. One hospital has bought a new, faster blood analyzer explicitly to save on technician time, without having to balance the cost of the machine versus the labor expense it would save. Accounting procedures also have been distorted. Hospitals capitalize everything they can, even trivial expenditures, to obtain capital reimbursement.

Most hospitals are concerned about prospective payment for capital and feel: "Prospective payment for capital would be a real hardship for us." Especially vulnerable were one hospital which has just completed a major renovation and another which has a very old plant and must renovate soon. "There has to be grandfathering of old capital and a long transition."

The current uncertainty over future capital reimbursement is having two diametrically-opposed effects. Some hospitals are postponing capital expenditures, adopting a "wait-and-see" attitude. Others are spending immediately, hoping to qualify for any grandfathering of "old" capital.

3.5.6 Physician Incentives

Hospital administrators think "physicians don't have enough incentive under PPS to get efficient. Hospital and physician incentives often conflict." Doing so would make the hospital's job of providing quality medical care at a reasonable cost much easier. Several specific examples of conflicting hospital-physician incentives were mentioned. Because of the threat of malpractice suits, physicians still have incentives to practice costly "defensive medicine." They want to keep patients in the hospital longer and order more tests than the administration would like. In one rural hospital, the administration complains that they have difficulty in persuading physicians to discharge to swing beds even though that is in the best financial interest of the hospital. This is because physicians can bill for only one visit per week to a swing bed patient whereas their billing is unlimited for acute-care patients.

3.5.7 Quality of Care

A number of hospital personnel think that PPS is causing premature discharge from the hospital for some patients. "Length of stay has declined too much. People are recovering at home when they should be in the hospital." Rural CEOs are especially concerned about the PPS incentive for earlier discharge. Fewer home support services for the elderly exist in rural than in urban areas, they observed, and in rural Iowa, many young people who would care for elderly relatives, if present, have moved away because of poor economic conditions. Physicians, therefore, are reluctant to discharge patients who are unable to fully care for themselves. Yet, if patients remain in the hospital, the hospital loses money.

Rural CEOs also worry about the prospect of many rural hospitals closing. They felt that it will then be difficult for the elderly, who are less mobile than the young, to obtain adequate medical services.

Even attracting doctors to rural areas would be difficult without a hospital. A number of managers, both urban and rural, think that "some patients who should be getting into the hospital are not because of the PRO." The rural hospitals feel that communication with the PRO, done by mail and phone, is inadequate.

On the whole, however, hospital administrators do not think PPS has resulted in a major decline in the quality of care to this point. Some are pessimistic about the future, however, if the budgetary screws continue to be tightened. Several noted the increasing number of procedures performed by doctors in their offices and felt that this trend towards extra-hospital surgery and testing would diminish the quality of care. One summarizes it as "It used to be quality of care, quality of care, quality of care, now it's dollars and cents, dollars and cents, dollars and cents."

4.0 PPS AND ALTERNATIVE HEALTH PLANS

4.1 Structure of the Industry

Waterloo has one operational HMO that was originally sponsored by the John Deere Company in 1982. Typical of company initiated HMOs, this plan was started as a cost containment strategy to lower health insurance costs. Being locked into a rich (and expensive) benefit package, the plan was established as an independent practice association (IPA), contracting with most local providers to retain the wide consumer choice available under its indemnity plans. The strategy was to enroll the members by offering comparable benefits and then establish utilization controls that would limit the costs of services provided. Presently the plan has 30,000 members, or a 15-20 percent market share. The HMO limited its growth initially to 10,000 enrollees in each of the first 6 months of operation. This cautious plan allowed time for providers in the area to get used to the HMO and its utilization review controls, and for the plan to stabilize.

A year ago, the health plan was assumed outright by Deere's subsidiary HMO chain, which in turn contracts back to the plan for the provision of medical services. Each plan retains its financial independence but pools its administrative functions and overhead costs with the parent corporation. Each plan gave up some autonomy, however, in determining its benefit package offerings and pricing. For example, the parent corporation seeks individual plan input into the design of the benefit package and contracts with providers (especially for ancillary services), to promote the plan and ensure local physician support. Minor differences between plans exist in copays and deductibles, but the discrepancies are slowly being eroded as the parent organization streamlines its product. The new organization allows the plan to market risk contracts by providing greater access to capital. In addition, the administrator thought the move would allow the plan to offer maximum benefits and provider availability given its stronger financial position. Specifically cited advantages were the ability to guarantee a rate structure to smaller, higher risk groups and to offer contracts to groups that could not self-insure.

4.2 Competition

Given the strong position of the existing HMO and the declining rural economy, Waterloo has not been a prime target for other HMO activity. The only exception is a nascent Blue Cross sponsored PPO. With its solid financial backing and wide consumer choice, the HMO undoubtedly presents stiff competition to any potential entrant. Moreover, the area's declining economy presents real problems for any newcomer's marketing strategy.

Prior to its incorporation into the Deere subsidiary, the HMO had not considered federal qualification for two reasons. First, federal qualification requires that rates be community based, whereas Deere wanted to experience rate its group. Because Deere was the dominant

source of enrollees, there was no real pressure for the development of community rates. Second, the HMO was originally designed as a cost containment initiative, without focusing attention on the broader role it could play in servicing other employee groups in the community. Once the HMO was successful at bringing Deere's costs down and, due to layoffs, the number of employees had decreased, the HMO's focus shifted to a broader base of enrollment. The parent corporation is presently awaiting federal qualification for both of its Iowa plans.

4.3 Contracting with Hospitals

Deere's rich benefit package (including full coverage for physician office visits, approved hospitalizations, all ancillary services, and home care) and the fact that, like most alternative health plans, the HMO's main competition is indemnity insurance have resulted in unusually high access to services for its enrollees. The Waterloo HMO does not selectively contract with providers, but uses all nine hospitals in the area. To encourage hospital participation, the HMO paid billed charges for the first year of operation. The second year it shifted to a hospital-specific per diem payment. Since the third year, the four local hospitals comprising the majority of the plan's hospitalizations have been paid hospital-specific DRG rates for employee group members. Low volume, outlying hospitals are paid billed charges. One hospital was paid capitated rates but this payment scheme was dropped after one year due to administrative requirements that outstripped the plan's computer capabilities.

No particular effort is made to use low-cost hospitals; rather physicians admit to any local hospital where they retain admitting privileges. All non-emergency hospitalizations require physician approval, including referrals to specialty hospitals. Hospitals are not at risk for non-approved admissions. In the case of physician-approved services, the physician is liable, whereas in cases where the hospitalization was not approved or exceeded approved services, the subscriber is liable. Medicare admissions are excluded from any hospital contract and are paid at the Medicare DRG rate. The Medicare rates will be higher than the hospital-specific DRG rates because, compared with regional and national norms, the hospitals are lower cost providers.

Out-of-area hospitals receiving referrals from the HMO are paid billed charges. Two hospitals often referred to (the University of Iowa Hospital in Iowa City and the Mayo Clinic in Minneapolis) have "letters of agreement" with the plan allowing them to directly bill and be paid monthly as with the other local hospitals. These claims are held up for payment until their physician authorization is verified.

4.4 Contracting with Physicians

The plan currently has contracts with all physicians in the area except one, who decided against participation in the plan and all ancillary service providers. Because the plan operates as an IPA and has no auxillary medical personnel to act as gatekeepers, enrollees have

direct access to primary care physicians. Specialty services require referral by a primary care physician and, similarly, non-emergency hospitalization requires pre-authorization.

Physician payments, durable medical equipment, and ancillary services are based on fee schedules determined by a physician peer committee, using Blue Cross's Usual and Customary charges as a benchmark. Fees are negotiated at the beginning of the year with individual practitioners. Physician payments often exceed Blue Cross's Usual and Customary charges because the schedule is set by peer physicians. The "spirit of cooperation" prevails, with physicians controlling both the quality assurance program definitions and financial payments. As the medical director acknowledged, "we didn't skimp (on payments or quality assurance) and therefore we didn't alienate anyone when we were starting up." The administrator put it slightly different, stating that they don't use "a heavy hammer with the physicians, but rather have found an equitable balance between cost control and allowing providers to survive." Physician participation is good.

Although physicians are not paid on a capitated basis, the plan retains 10% of physician payments for services rendered as a contingency in the event of an IPA deficit and to act as an incentive to keep utilization low. The physicians are at risk for the first 20 percent of any loss for the year within their physician fund. If there is a physician fund surplus, doctors are entitled to 100 percent of it. Any physician fund deficit exceeding 20 percent is funded by the plan. For payment of hospital and ancillary services, separate funds are used. Physicians do not share in the risk of over-utilization except in cases where the hospitalization was deemed inappropriate yet was approved by a physician. In these cases, the first two inappropriate approvals are paid out the of general fund, with no financial risk assumed by the physicians but with a warning delivered after the second infringement. Any additional claim is paid directly by the physician involved. In cases where utilization exceeds anticipated projections, the plan will assume all financial losses. As an incentive to keep utilization low or in the most cost effective setting, the plan shares 20 percent of any general plan surplus with physicians.

4.5 Marketing Strategy and Benefit Availability

Because there are no other HMOs at this site, the plan has kept its benefits generous to remain competitive with Blue Cross indemnity coverage. The plan competes with traditional insurance based on price, offering lower co-payments and deductibles on most services. In addition, it offers three different options, corresponding to different levels of coverage, in an effort to meet consumer demand. The plan has had good success in enrolling employees with its lowest participation within an employer group at 53%, and averaging 75% participation across employer groups.

In selling the plan to potential employer groups or individuals, several points are made. First, the comparison of benefits and out-of-pocket expenses are made to show its lower co-payments and

deductibles. Second, its service availability and accessibility are emphasized since the plan does not limit consumer choice or access to primary care. Third, employers are offered special group specific reports analyzing cost and utilization trends. These analyses can assist employers in tailoring benefits and improving utilization controls in problem areas.

Since PPS, benefits have changed for the senior plan (its wrap around coverage for Medicare beneficiaries) due to the significant increases in prescription drug costs. A deductible ($100) and maximum cap ($1,000) were instituted, significantly reducing the benefit.

With the decline of the "core" of the plan's membership base (since Deere has laid off 11,000 workers and another factory has completely closed), the plan has had to turn to smaller employer groups to continue its growth. Its targeted groups now include small to medium sized firms with 50-200 employees, many of which can not afford the rich benefit package that Deere employees have. To meet this shift in demand, the plan has carefully developed and priced its low and medium option plans. Long term expansion plans include other Iowa sites and locations in other states, and eventual diversification into other product lines such as dental, podiatry, chiropractic services, and worker's compensation.

The plan combines community and experience rating in developing premiums for different sized groups. Large groups (over 1000 employees) are experience rated. No health screening or pre-existing conditions clauses are used to limit enrollment in any group. Small groups (less than 100 employees) are strictly community rated. Medium sized groups have a combined community and experience rating, with the weight of the experience rating varying with the credibility of the estimates derived from the information supplied by the group. For example, if a benefit was previously not available or the experience cannot otherwise be relied upon, more emphasis is placed on the community rating. Claims experience under previous carriers is requested, broken down by hospital, physician, major medical, drugs, and other costs. In addition, previous premium rates are requested, providing valuable information about its competitors' pricing policies. The plan uses these prices in determining the price of its premium package offered to the potential group.

4.6 Utilization Review

Given the rather liberal access to physicians and generous payment practices, the HMO has sought to control cost through careful utilization review. All local hospitalizations are placed under concurrent review with daily examination of treatment plans and services delivered. Admissions at remote or referral hospitals are monitored daily by telephone. As described previously, physicians are at risk for unnecessary hospitalizations (after the first two incidents) and share in the savings from underutilization. In combination with the withholding of 10 percent of physicians' payments contingent upon appropriate (low) utilization, these management tools have reduced utilization substantially--for example, previous Deere employee utilization in the HMO was at 800-1100 days per 1000 population and has stabilized at

450-490 days. Other cost containment strategies include preauthorization for the use of specialty and referral services, preadmission testing, and the monitoring of practice patterns of individual physicians. These studies analyze referral rates by specialty and by service to identify both high and low users of services. The Iowa legislature has also mandated that all HMOs perform random audits of ambulatory services to ensure that HMOs are not underservicing their enrollees.

The utilization review process is similar to that performed by most PROs with one major exception: the review is done concurrently, allowing the plan to have far greater control over the utilization incurred by plan members. Non-Medicare admissions at the local hospitals are reviewed daily by nurses, with physicians acting as advisors on questionable cases. Medicare admissions are not reviewed until the utilization enters the coinsurance phase when the plan is responsible for any costs incurred. Non-local admissions are monitored by telephone.

Disagreements between the attending physician and the plan are decided by a Quality Assurance Committee, with an appeals process available for continued disagreements with either the patient or attending physician. This Committee is also responsible for evaluating experimental procedures, reviewing the use of high tech services, and approving out-of-area specialty referrals. All post-hospital services, accounting for a small amount of services provided to enrollees, are reviewed retrospectively for appropriate authorization and utilization. Presently, the low volume at the plan does not warrant case management but this is one service the parent corporation is implementing in its other sites.

While the HMO does not have written protocols for care, patient care is profiled and compared by DRG using the ICCIS InterQual System. Lengths of stay and ancillary usage are monitored daily at the hospital and admissions must be recertified every three days. Utilization that was mentioned as having been made more appropriate included the decrease in hospitalization for general backaches, decreases in lengths of stay for psychiatric admissions, reductions in allergy testing, and the elimination of "gimmick" medicine.

PPS has had one important impact on the plan -- by using DRGs, Medicare paved the way for a more effective method to control costs than the per diem methodology it was using at the time. Thus, although Medicare enrollment is low at the HMO and does not dominate its operations, its payment practices eased the implementation a more restrictive cost containment tool--DRGs. The plan's emphasis on concurrent review and home care predated PPS and should not be interpreted as a side effect of the payment system. In addition, many of the PRO standards are not used because they are too lenient for monitoring their lower utilization rates typical of the plan. The plan's reviewers have reportedly noticed some DRG creep (e.g. the use of critical care codes in admission or follow-up visits in the cardiac care units) and the shifting of patients to non-DRG units (often hospital-based SNFs), indicating similar gaming of the payment system that Medicare faces.

4.7 Medicare Enrollment

About 10% of the plan's enrollees are members of a Senior Care Plan that provides Medicare wrap-around coverage. Two thirds of the Medicare enrollees are Deere age-ins (persons previously covered by the plan and becoming Medicare eligible). The plan has not aggressively marketed its senior care benefits; in fact, recent open enrollment for new members was carefully limited to 1,500. The cautious growth reflects the area's general distrust of federal government and the perceived difficulty of marketing a risk contract to local physicians. Thus, while the director acknowledged a wide open potential for market expansion, he said it was not one the plan would actively pursue in the near future. Without aggressively marketing the program, the plan hopes to add 40-50 new enrollees a month until it can better assess the financial viability of a more aggressively expanding program.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Background

Physicians in Northeastern Iowa have modified their conservative patterns of practice in response to PPS primarily in terms of admissions. Medicare admission rates are lower than either the national average or the previous area average, particularly in the rural hospitals, both because of PPS and economically-induced outmigration. Lengths-of-stay have also fallen. There are exceptions where little change has occurred, especially among older physicians in rural areas. In general, these changes are described as responses to PRO review and to implicit understanding of the new environment rather than to explicit hospital pressure.

Urban hospitals have responded to declines in patient census by actively recruiting specialists. Community hospitals in the smaller towns and rural areas around the Waterloo/Cedar Falls MSA often transfer especially difficult cases to the urban hospitals, where more specialized knowledge and technology are available. The regular visits of urban specialist physicians to many of these smaller hospitals reduces the referral "leakage" problem, providing the expertise required on-site.

The history of formal utilization review in the Northeastern Iowa area is of at least ten years' duration and predates PPS. Although review was formerly done with local hospital involvement, it is now centralized in the PRO, the Iowa Foundation for Medical Care (IFMC). IFMC maintains a high visibility and its activities are strongly resented by some physicians.

5.2 Admission Controls

The most acutely felt effects of PPS seem to be physicians' reluctance to admit Medicare patients for fear of PRO denial and sanctions and a reinforcement of the already existing trend towards outpatient surgery. The PRO reviews a 3 percent random sample of admissions. IFMC also reviews all readmissions made within 15 days of discharge with the same diagnosis and all transfers to PPS-eligible units. Physicians are put on three months preadmission screening if 2 1/2% or more of their Medicare admissions are retrospectively denied. While physicians respect the PRO, its clout, and its standards, some complain that the PRO review is a paper exercise in which clinical judgment and evaluation cannot be exercised by the reviewer and that the reviewer might not always have the specialized knowledge required by a particular case.

Physicians note that the push for outpatient treatment, especially outpatient surgery, precedes PPS, and they generally support it; outpatient surgery is increasing for all patients, not just the elderly Medicare population. A few doctors report that they are able to see more patients and perform more procedures on an outpatient basis because they are freed from the need to make inpatient rounds. Orthopedic surgery is

increasingly being done on an outpatient basis or with early "transfers" to swing beds or SNF beds. As in other sites, no utilization review seems to be done on outpatient surgery.

5.3 LOS/Intensity Controls

While DRGs are sometimes coded at admission for Medicare patients, case study hospitals vary in whether or not DRGs maximum payments, national average LOS, outlier cutoff days, or running charges (as approximations of cost) are noted in patients' charts or otherwise made known to physicians concurrently. Rural hospitals typically do not have computer facilities to track charges on a timely basis, but at least one rural hospital computes running charges manually and enters them on patient charts. Although ancillary charges are not always monitored, there is anecdotal evidence to support the contention of both a reduction in lab work per inpatient case as well as a reduction due to the lower overall number of inpatients.

Some urban hospitals use IFMC's SI/IS (Severity of Illness-Intensity of Service) screening system for their own concurrent utilization review; cases not meeting screen criteria go to an in-house medical committee for review. Generally, pressures on the physician to discharge earlier are indirect and subtle, less often a matter of explicit badgering by nurse reviewers (although this too was sometimes cited). One urban hospital, which does not put DRG payment and charge details on charts, does post on the wall in the doctors' lounge a list of Medicare "winner" and "loser" patients' information identified by attending physicians' code numbers.

Physicians accept an accelerated discharge planning process, often initiated within a day or two after admission and conducted primarily by nurses and social workers with less physician input than was previously the case. Earlier discharges, including those to swing beds (for which doctors can bill fewer visits), to some extent pit hospitals and doctors against each other. The hospital's economic interests are best served (remuneration under DRGs optimized) by early discharges, whereas the physician's optimal practice pattern is frequent (often daily) visits and billings to each of a cluster of patients conveniently located in the hospital's acute care service. Physicians also feel more exposed to malpractice suits that can stem from premature discharge. Physicians often acquiesce to early discharges in consideration of the hospital's continued viability and survival, rather than for fear of hospital sanctions.

5.4 Specialization and Other Responses to PPS

Most hospitals and physicians acknowledge they have identified DRG "winners" (coronary bypass surgery, transurethal resection of prostate, adhesion surgery) and "losers" (pinning fractured hip, total knee and total hip replacements, nephrology, pacemaker implant). Losers are more readily identified than winners. However, no actions have reportedly been based on this knowledge.

Swing beds are considered by many to be "HCFA's gift" to rural hospitals and a much-needed boon to their financial viability; the swing bed program is felt to be a positive and very important aspect of PPS. In small hospitals, physicians often continue to visit patients in swing beds while on their regular daily rounds, even though only one physician visit in a three-day period can be billed to the account of a swing bed patient.

At least one rural hospital has also instituted "medical short stay" beds in a 24-hour observation room which permits overnight evaluation (e.g., in cases of respiratory difficulty/suspected pneumonia) without actual inpatient admission. This innovation has obviated the need for "questionable admissions" of the elderly, which have been cut under PPS.

5.5 Quality of Care Impacts

Although most physicians bemoan "slower, sicker" admissions and "quicker, sicker" discharges under PPS, none are convinced that bottom-line quality of care is being compromised. Some physicians and hospital staff complain that the media contribute to patient and family perceptions that doctors and hospitals (not Medicare) are being "heartless" in promoting recuperation outside the hospital in the subacute phase of an episode of care. For example, families of the terminally ill often feel that the patient "belongs in the hospital " until the hour of death. These problems are exacerbated in this area because the exodus of young people from the Northeastern Iowa area in pursuit of better economic opportunities has left many elderly patients without at-home familial support. This problem is only partly alleviated by the existence, in the smaller towns, of more community supports.

Other PPS contributions to the practice of medical care in Northeastern Iowa are better documentation, improved quality of care attributed to the oversight and review process, and more education of patients in preparation for self care at home.

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

The aftercare industry in northeastern Iowa has changed significantly since the Prospective Payment System was implemented. In general, patients are discharged earlier and sicker, though few interviewees think that the level of care is inappropriate. Several home care providers mention the development of "high tech" services in the home due to increased demand for this level of care. Similarly, nursing home administrators have had to take patients requiring more skilled services as hospitals discharge the patient once the "DRG is up."

Increasingly, hospitals have moved into aftercare by staffing skilled nursing home beds and starting home health agencies. This development has allowed hospitals to provide a "continuum of care" from the inpatient setting, to the nursing home, and then home. It is also an alternative source of revenue, given the decline in inpatient utilization and excess hospital bed capacity in the area. Hospitals had developed long term care beds in the past, but had eliminated them during the late seventies, due to low reimbursement. With the advent of PPS, several area hospitals have reexamined the financial feasibility of SNF units and found them to be an attractive complement to their acute care units. Four hospitals have therefore opened SNF units as a direct response to PPS. In addition, PPS has also provided incentives for hospital-sponsored skilled services and durable medical equipment in non-hospital settings.

6.1 Discharge Planning

Discharge planning in Waterloo is done primarily by social workers and the nursing staff. In one hospital, the social service department has lagged behind trends in arranging for a variety of home care options, preferring to see itself as a nursing home placement and financial planning service. In this case, nurses take the lead role in discharge planning. In hospitals without home health agencies, agency representatives make frequent visits to the hospital looking for referrals and, consequently, assist in discharge planning. Prior to hospital-based agencies, such "coordination" of services was more common.

Unlike their larger, more urban counterparts, discharge planners at two small rural facilities at this site feel that their discharge planning efforts have changed very little since PPS. Physicians continue to dictate when patients are to be discharged and what services are to be ordered. Moreover, physician practice patterns have changed very little as a result of PPS. This experience stands in stark contrast to other facilities and other sites, where the physician's role in discharge planning has been reduced to signing order forms and discharge papers.

Discharge planners assess the patient's needs, recommend services, and, if preferred by the patient and family, make arrangements for services once choices have been made. As a result of PPS, the discharge planning process begins much earlier during the admission, often at admission or even prior to admission in the case of pre-authorization for elective procedures. Many hospitals use normal high risk profiles to

flag likely candidates for discharge planning, such as stroke, hip, and cancer patients, and those over 70 years old, with no immediate family in the area, or with few financial resources.

Because patients are in the hospital for shorter stays, patient teaching and training have been significantly curtailed. In addition, patients are sicker at discharge and can be more difficult to arrange services for. One planner thought that some discharges have been premature and have resulted in readmissions. On the admissions side, tighter admission criteria result in sicker patients being admitted than prior to PPS. In one hospital, physician complaints about pressure to discharge patients have led the discharge planners to slow their efforts.

Over half of the hospitals in the area have SNF, ICF, or swing beds, or some combination thereof, allowing hospitals to transfer patients easily between different levels of care. The exact role of swing beds in hospitals with long term care facilities is a potential concern. Hospitals could use the swing beds simply to augment revenues prior to final transfer to a long term care bed, regardless of prior availability. Planners mention having placement problems with hospitals' long term care facilities and that swing beds are used for patients awaiting transfer. In an area of SNF bed surplus, this queuing problem appears to be a misallocation problem, reflecting physician and patient preferences rather than a shortage of beds. Title XIX patients present a separate placement problem, given most facilities' preferences for higher paying patients.

6.2 Home Health Agencies

Home health care is a growing business in northeastern Iowa, with many of the area's hospitals expanding into what was exclusively the domain of a visiting nurse association prior to PPS. In addition, one county runs a home health agency, providing visits to many rural locations. None of the independent agencies have contracts with hospitals, although they would like to have such a guaranteed source of patients. There appear to be some selective referrals from hospital-based programs to the non-profit VNA and the county home health agency, based primarily on economic status and Medicare eligibility for coverage of required services. In general, there has been considerable growth in the number of patients served and the proportion of Medicare referrals.

In addition to the increased volume of services, there has been a marked increase in the intensity of services delivered in the home. Typical services now performed by visiting nurses include IV therapy (including chemotherapy), severe wound redressing, intravascular injections, tracheotomy changes, respiratory therapy, hyperalimination, and ventilator monitoring. To meet this increased intensity, nurses have had to receive some in-service training for wound dressing, IV therapy, and improved patient assessment. One hospital-affiliated program was started in direct response to the lack of high tech services being delivered by other area agencies. Two agencies mention that because

hospitals have developed SNF units, the severity of patient has been limited because the very sick patients are placed in the long term care unit rather than discharged home.

The home health agencies are consistently providing services that are not covered. These include services that do not meet Medicare skill level requirements, assessment of patient needs, and training and teaching of patients and their families. This latter service used to be provided during the last days of hospitalization but with shortened lengths of stay, this responsibility often falls to the home care providers. This is a clear transfer of cost that Medicare has avoided since it implemented DRGs. The residents of Waterloo have also developed an informal network of sitters who visit elderly in their homes. These sitters are paid hourly wages out-of-pocket, another example of cost-shifting, in this case privatization of costs.

The home health agencies have few complaints about the fiscal intermediary, Blue Cross of Iowa. The FI tends to inquire about services provided, not actually deny claims, and is very flexible in its definitions of "homebound." One provider mentioned how time-consuming it is to process the documentation required for appeals. Another comments that information about policy changes are often late.

The providers all say they have a clear understanding of what definitions are being applied. Disagreements arise over definitions of "intermittent" and "medical necessity" due to the inherent ambiguities in these areas. In general, the providers simply wanted to know what the rules are--they can learn to live within the regulations somehow. When rules change, considerable confusion sets in until trial and error and verbal communication with the FI have cleared up the new interpretations. Several interviewees mention how hard it is to get timely answers to questions about policy, and that written responses are virtually impossible to obtain. One complaint is that there are regional differences in what services are approved, apparently due to differences in reviewers. Such discretionary power over denials is expected to be reduced when the regional processing of claims takes place. About half of the providers at the time of the interview did not know when or where regional processing of claims would occur and reserved judgment about how this would affect their claims approval and processing.

6.3 Nursing Homes

As mentioned above, several hospitals have opened up SNF and ICF beds due to the implementation of PPS and the excess acute care bed capacity. Because physicians prefer to transfer patients to these convenient and known facilities, beds may appear to be in shorter supply than they actually are.

In general, patients are leaving hospitals earlier and sicker, forcing homes to increase their staffing complements and skill levels. The rapid change in the SNF population with respect to acuity of illness has actually outpaced changes in regulations. SNF units must maintain outdated, lower level service capabilities when compared with the needs of the present SNF population. Providers have responded to the increase

in patient severity by providing needed services beyond the mandated minimum levels, for example in frequency of physician visits and hours of care per patient per day. As a result of these discrepancies between service requirements and services actually delivered, Medicare per diem rates are reported to be substantially below costs at some homes.

One provider reports that a few patients have been discharged too early and that the home has had to send these patients back to the hospital. This administrator feels that hospitals do not like to keep patients who are dying--they would rather transfer them to minimize their incurred costs. Another problem for the homes is a result of those patients not sick enough for skilled services--these patients tend to fall between the cracks of coverage and, hence, service provision.

Homes have begun to combat hospitals discharging patients with no advance notification by requiring that all transfers be accompanied by a referral packet outlining service needs, medical history, financial statement, and responsible party of the prospective patient. This requirement has cut down on the late afternoon dumping that had reportedly been taking place.

Nursing homes have had other difficulties with hospitals in coping with the effects of PPS, specifically the admission of surgery patients on the day of surgery. Homes have a hard time getting patients transferred at 5:30 a.m. Another problem is the intensified screening of patients upon admission for appropriate documentation. Patients have reportedly been denied admission and sent back to the home, only to be sent back to the hospital the following day for admission by the patient's attending physician.

Given the relatively low volume of Medicare patients, homes do not have any complaints about the fiscal intermediary. Increasingly restrictive definitions of "skilled" services as well as inadequate rates are seen as poor HCFA policy, not as a shortcoming of the FI.

7.0 PROGRAM OPERATIONS

7.1 Peer Review Organization

7.1.1 Administration

The Iowa Foundation for Medical Care (IFMC) is the Peer Review Organization for Iowa and Nebraska. The IFMC began 15 years ago with the experimental Medical Evaluation Program, the precursor to the Professional Service Review Organization. The IFMC is in its second contract, which was awarded without competitive bidding, due to its solid performance during the first round of contracts. Both the Executive Director and the Executive Vice President have been at IFMC since the organization was started in 1972.

The IFMC currently has over 175 employees, performing review for a variety of customers including the Medicare Program. Having once been the only client, the Medicare program now comprises only 50 percent of IFMC's activity. Another 30 percent of its business comes from the Medicaid program, for which it does both acute care and long-term care review. The remaining 20 percent is done for private clients, most notably the Deere Company and Blue Cross of Iowa. IFMC has recently formed a subsidiary corporation to develop further private business in the St. Louis market.

The IFMC is unusual not only for its variety of clients but in the scope of work performed. In addition to performing review of long term care and acute stays, the IFMC markets its data processing software to other organizations, performs data processing for a drug utilization review program for Iowa pharmacies, and reviews disability claims. Finally, the IFMC is actively engaged in research on regional variations in medical practice patterns. Using small area analysis, the IFMC is identifying potential problem areas of exceptionally high or low utilization for focussed review activity. IFMC was one of the most sophisticated PROs visited in the ten case studies.

7.1.2 Super-PRO Ratings

The IFMC met or exceeded all of its objectives except that for readmissions, which it has subsequently targeted by instituting a pre-discharge review program for physicians who discharge prematurely. In addition, due to the high number of SNF beds, discharges to these units are being examined. Other potential problem areas include DRG validation and admission denial rates. The Super-PRO is concerned that the disagreement rates for these and other areas have increased during the past three quarters. The PRO is therefore requested to analyze these findings and report back to the Super-PRO. In general, the PRO is very satisfied with the Super-PRO review, saying that it has done an excellent job of pointing out leniency in IFMC reviews.

The PRO consistently reviews more claims than the necessary minimum or the national average. This is because Iowa has a high number of swing beds that warrant special attention. For example, in recent PRO

negotiations on its second contract IFMC proposed reviewing almost 8 percent of all cases, whereas the national level of effort is at 2.5 percent.

7.1.3 Quality Assurance and Record Review

In the past two years, IFMC has shifted its review activities from delegated, hospital-based UR programs to independent, locally based peer review as per the mandate by HCFA. IFMC has sought to improve consistency between reviews by reducing the number of peer physician reviewers. Currently, all reviews are done by RN's (75) or medical records specialists (5). At 30 of the 130 hospitals, records are reviewed on site.

Predetermined review criteria (Severity of Illness/Intensity of Services criteria) are used to determine appropriate medical care for about 80 percent of the cases reviewed. Any problem records or potential denials are then referred to a physician reviewer who gives written determinations to the nurse reviewer. Generally, the nurse reviewer communicates directly with the attending physician about disagreements over the care delivered to the patient. All formal denial letters are written by the physician reviewer. About 32 percent of all records end up being reviewed, in part because over 90 percent of the hospitals have swing beds, and because the five mandated procedures comprise a larger percentage of their cases than the national average.

The PRO carefully monitors the internal validity of its review staff by making monthly comparisons of referral rates to physician reviewers and denial rates of all reviewing staff. Quartile bars indicate outlier reviewers and suggest areas for improvement in consistency between reviewers.

7.1.4 Denials and Sanctions

At any time, about five percent of Iowa's physicians are under intensified review. During its first quarter of PRO activity, IFMC sent out over 1000 letters to physicians. Once physicians had adjusted to the PRO utilization review criteria, many problems disappeared. Several persistent problems remain, however, including premature discharging, misdiagnosis of MIs, inappropriate use of antibiotics, and readmissions for certain diagnoses and isolated physicians. Two physicians have been sanctioned (one is pending), and another twenty have been notified that the sanctioning process has been initiated. The PRO acknowledges that physicians often need the severity of this last step before they will listen to the peer physicians' recommendations.

7.2 Fiscal Intermediary

7.2.1 Administration

Blue Cross of Iowa, located in Des Moines, is the fiscal intermediary (FI) for Iowa. It will become the regional processor for

home health care claims for ten states, handling the business of over 380 providers. Having been an alternate regional intermediary for many out-of-state providers when the Office of Direct Reimbursement was eliminated, it foresees no real problems in expanding its operations.

More generally, BC has no unusual administrative problems to report. The FI staff feels that it does an excellent job of informing hospitals of their DRG rates (including how they were calculated) and payments made. Unfortunately, reportedly through no fault of its own, the updates to the rates are not always timely. Often Blue Cross does not receive final versions of adjustments to be incorporated into its software until close to (or even past) their implementation date. Consequently, the rates have to be retrospectively applied to payments already made. The FI reports that every time the grouper or pricer software has to be modified, its programmers must spend at least one week getting the changes tested and operational; this also slows implementation of changes.

The FI has been impressed with efforts by HCFA to increase the consistency between FIs as regional intermediaries for home care. The regional FIs have met twice to discuss definitions and interpretations to ensure uniformity between FIs. To inform new providers of definitions, documentation requirements, and procedures, it has planned two-day seminars in each of the nine new states.

7.2.2 Claims Processing

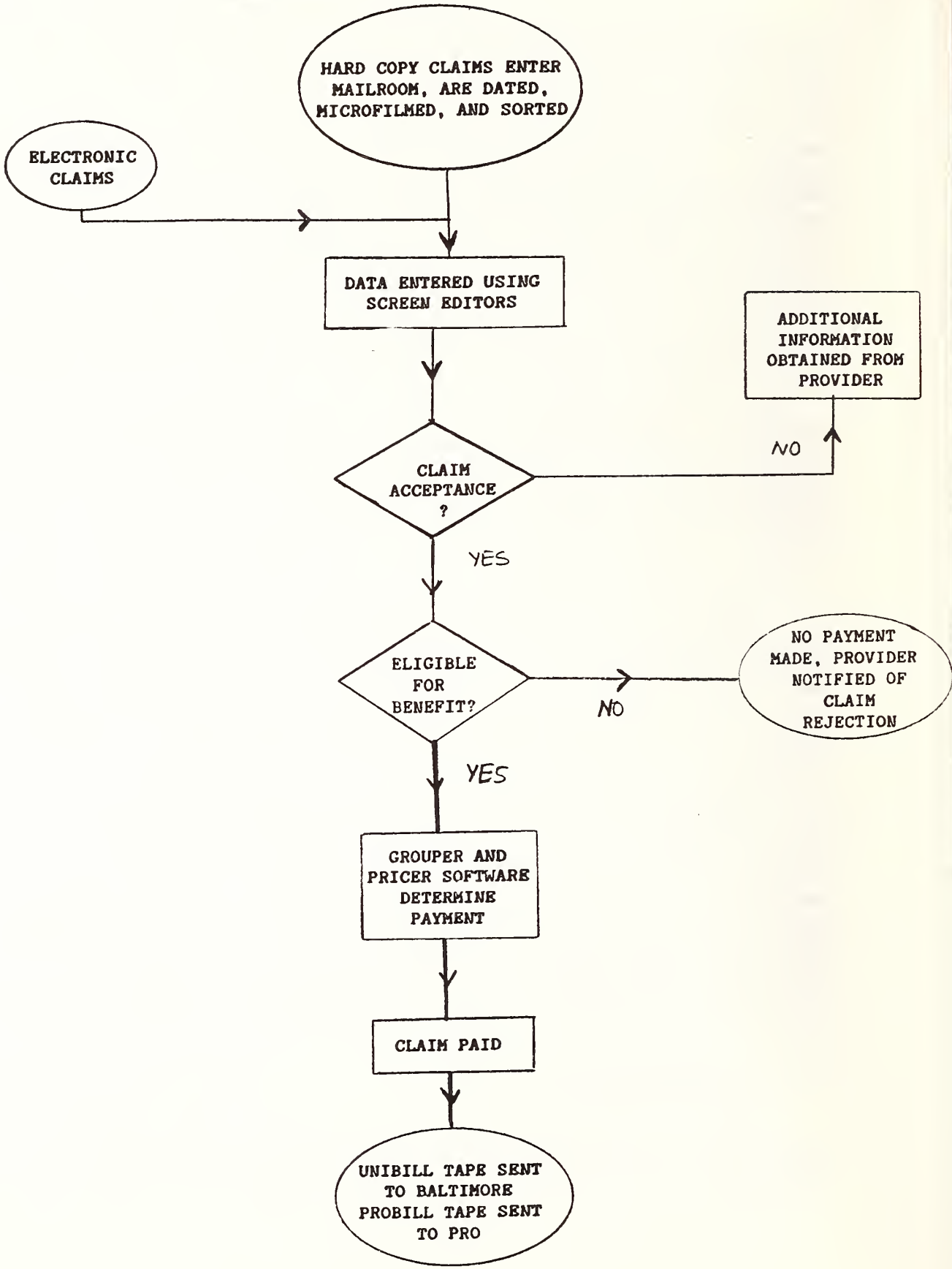
Figure 1 outlines the process by which claims are validated and paid. About 45 percent of the claims enter the system electronically. BC encourages providers to shift from hard copy to paperless by paying the former group only once a month. Once claims have been keyed in or read, edits are done to validate accuracy and completeness. Problem claims are sent back to providers or completed manually after calling the provider. About 15-20 percent of the home health claims are rejected using these simple edits.

Eligibility for Medicare payment is determined in Baltimore and sent back to Iowa, taking about three days. Acceptable inpatient claims are run through grouper and pricer software and are then ready for payment. The PRO has on-line communications with BC, allowing PRO immediate access to processed claims. Average processing time for inpatient claims is reportedly 10-15 days, including the time required for eligibility determination. BC of Iowa is implementing additional computerized edit screens developed in Wisconsin for determination of medical necessity and skill level of home care services rendered. These computerized edits are an attempt to eliminate discrepancies between reviews of similar cases.

7.2.3 Utilization Review

Medical review of SNF, outpatient, and home care claims is performed by a staff of 26 RNs, with assistance from two physician consultants. The reviewers have noticed the quicker discharging of

FIGURE 1 - BLUE CROSS OF IOWA CLAIMS PROCESSING


HARD COPY CLAIMS ENTER MAILROOM, ARE DATED, MICROFILMED, AND SORTED
ELECTRONIC CLAIMS
DATA ENTERED USING SCREEN EDITORS
ADDITIONAL INFORMATION OBTAINED FROM PROVIDER
CLAIM ACCEPTANCE ?
NO
YES
ELIGIBLE FOR BENEFIT?
NO
NO PAYMENT MADE, PROVIDER NOTIFIED OF CLAIM REJECTION
YES
GROUPER AND PRICER SOFTWARE DETERMINE PAYMENT
CLAIM PAID
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patients to the home setting without adequate patient training and an increase in physician office visits (avoiding hospitalization). The FI staff has also noticed more high tech in the home setting. One interviewee thinks that the circumstances are not always ideal for such care to be delivered in the home setting but the FI has yet to receive specific complaints or link readmissions to this care.

Based on the dramatic changes in the care delivered in the home setting, the FI has relaxed its interpretation of daily and intermittent care. While not changing its definitions, it has been more flexible in applying them. The following definitions are given by the FI:

intermittent: skilled nursing or home health aide services (not physician therapy), provided up to seven times per week. No termination date is required.

daily: skilled nursing or home health aide services provided seven times per week. End point required, but termination date can be well into the future (even up to six months) if medically necessary.

homebound: patient can not get to medical treatment so the care must be delivered at home. Patient can leave home routinely for non-medical purposes. Patterns of activity are reviewed.

skilled care: skilled nursing services, physical or speech therapy. Social worker and home health aide services can be covered only if another discipline is actively involved in the treatment plan.

The most problematic claims include those for services not medically necessary, services that do not meet minimum skill levels, and care given to patients with no improvement potential (care is custodial). In SNFs, patients receiving unnecessary physical therapy constitute the most denials. In general, however, denials are often due to technical reasons--incomplete forms, undocumented visits, and visits exceeding physician orders. In total, four percent of all bills processed are denied and seven percent of visits submitted as covered are denied. About two percent of all providers are off waiver of liability at any one time.

7.2.4 Relations with HCFA

The FI has good relations with the regional office in Kansas City, in part because a regional representative spends about a week per month at the FI. Contradictory signals from different offices are usually

ignored and orders are taken from their contracting office, BPO. Equally unsettling to the FI are cases of contradictory orders being given to the PRO and the FI.

The FI scores fairly well on CPEP, despite some mismatch between activities it deems important and areas that contribute to its CPEP scoring. For example, this FI places a lot of value on an accurate and effective audit department, even though about 70 percent of its activities contribute to only two CPEP scores. Thus, despite good performance in these areas, there are clearly other equally, if not more important, functions to monitor. The FI acknowleges some tension between what it wants to focus organizational resources on and what would improve its scoring. This tension was worsened by the lack of knowledge about how activities would be scored until after the CPEP scoring. Thus, feedback on any misfocus of its operations could not occur during the year but rather would shape net year's operations. Yet, there was no certainty that next year's criteria would be identical, leaving the FI to guess about the allocation of its resources.

BC has found the budgeting process to be a frustrating, if not futile exercise. The budget takes a lot of time to develop and it is not clear it is even used by HCFA in allocating dollars to this FI. Changes and delays in the budget have forced it to subsidize its Medicare administration with its private business while waiting for final budget approval and year end audit that approves payment supplements for increased claims volumes. An example of a subsidy is the shift of personnel to other assignments because their training is costly and they cannot easily be replaced on a short-term basis. Currently, Blue Cross is facing a shortfall on approved payment per claim ($1.77) versus what it proposed ($2.09). In addition to outright delays in payment, respondents complain that new responsibilities are sometimes added without renegotiation of the payment terms of the contract.

The FI hears numerous complaints from the hospitals about the inadequacies of the PPS payments. Specifically, hospital administrators think that the outlier payments discriminate against rural hospitals because the two percent of PPS revenues received as outlier payments fall short of the five percent by which the basic payment rate is reduced to fund the outlier pool. They see this as a redistribution from the rural to the urban facilities. Similar inequities are seen in the rural/urban distinctions in the wage index and the overly strict definition of disproportionate share.

The elimination of PIP will have a major effect on the small providers given their high variability in volume. Of the 32 hospitals currently on PIP, only 3 will retain this system because they are disproportionate share hospitals. BC will have to float some working capital to have cash available when the conversion from PIP to weekly payments takes place. Though minor (two weeks of working capital costs), this is one example of privatization of costs from the Medicare program. Another example is the elimination of eligibility of benefits at admission, resulting in the underwriting Medicare's cash flow by hospitals.

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